471-000-3 Instructions for Completing Form DM-5H. "Physician's Report on Hearing Loss"

USE: Form DM-5H "Physician's Report on Hearing Loss" is required for consideration of authorization for hearing aid(s). The hearing aid specialist coordinates the completion of Form DM-5H. The form is completed by the Hearing Aid Specialist and the client's physician.

NUMBER PREPARED: One copy of form DM-5H is prepared.

COMPLETION:

The following fields are completed by the Hearing Aid Specialist. The remaining information is to be completed by the client's physician.

FRONT:

Patient Name: Enter the Medicaid client's full name (first name, middle initial, last name).

Age of Patient: Enter the Medicaid client's age.

History: Complete the history segment with information obtained from the Medicaid client and/or
caregiver.

Typed Name of Physician: Type the name of examining physician. (This field is located at the bottom
of the page.)

The physician completes the remaining fields on the front portion of the form, and signs and dates the front of the form.

BACK:

The back portion of the Form DM-5H is completed by either the examiner or the provider of the hearing aid. The following information must be on the back of Form DM-5H:

1. Patient name, complete eleven-digit Medicaid number and age;
2. The name of the examiner or dispenser performing the audiogram;
3. Stability of hearing loss and previous hearing aid information;
4. A complete audiogram (pure tone, air, bone, speech);
5. The hearing aid recommendation with estimated cost;
6. The hearing aid specialist's Business Name, phone number and e-mail address; and
7. The hearing aid specialist's eleven-digit Medicaid provider number.

DISTRIBUTION: The Hearing Aid Specialist sends the DM-5H with a partially completed Form MC-9S (see 471-000-205) to:

Medicaid Division
Department of Health and Human Services Finance and Support
P.O. Box 95026
Lincoln, NE 68509-5026

Form DM-5H is retained in the Medicaid Division. Providers may wish to retain a photo copy of the form in their file.

To view printable form click here: Physician's Report of Hearing Loss

FORM DM-5H

PHYSICIAN'S REPORT ON HEARING LOSS

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM

Patient Name | Age of Patient

HISTORY

Is there a history of?

❑ Dementia/Alzheimers ❑ Severe Arthritis ❑ Chronic Middle Ear Pathology
❑ Visual Impairment ❑ Cognitive/Development Concerns

Does the patient wear glasses?

❑ Yes ❑ No

Other handicapping/medical conditions

Does the patient have the cognitive ability to use a hearing aid (remembers when to wear hearing aid, how and when to change batteries, and how to care for a hearing aid? ❑ Yes ❑ No

Are there support services available as needed? ❑ Yes ❑ No

Does the patient have adequate manual dexterity to use a hearing aid.? (Can place and remove HA, replace batteries, adjust hearing aid).

❑ Yes ❑ No

If no, does patient have access to support services for these functions? ❑ Yes ❑ No

Living arrangements

❑ Lives alone at home ❑ Lives at home with assistance ❑ Nursing facility

TO THE PHYSICIAN

The individual named above is a recipient of assistance. Medical findings on this form will be used in determining the need and advisability of providing a hearing aid.

PHYSICIAN'S EXAMINATION

Positive ear, nose and throat findings:

Diagnosis:

Do you feel a hearing aid will help this patient? ❑ Yes ❑ No

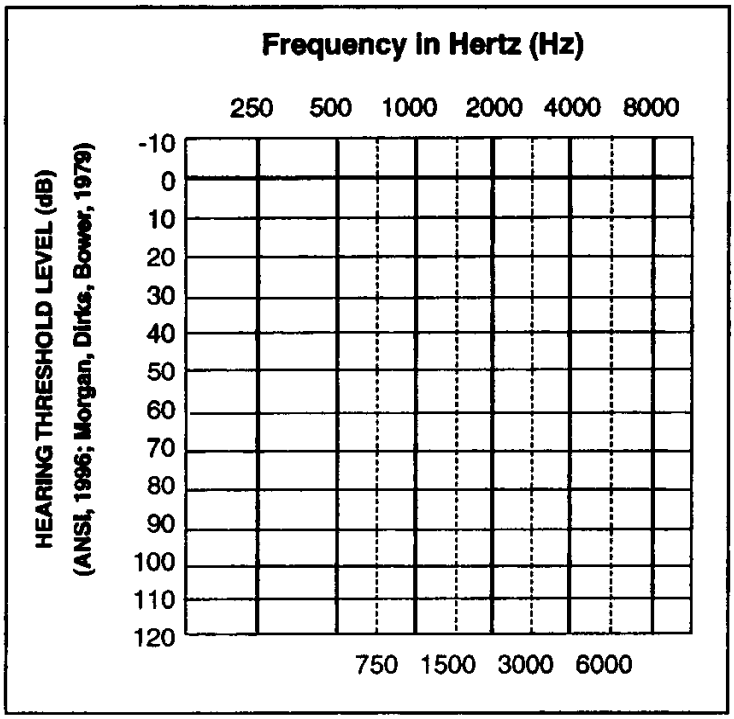
Recommendations and/or comments:

Date of Examination	Physicians License Number	
Typed Name of Physician		Sign Here _____ Signature of Examining Physician

HEARING EVALUATION

Patient Name	Medicaid Number	Age of Patient	Test Date	Name of Tester

Stability of Hearing Loss	Previous HA Use	HA Style	Age of HA	Reason for Replacement
❑ Stable ❑ Progressive ❑ Fluctuating	❑ Yes ❑ No			



Ear	SRT	Word Recognition	
		HL	%
Right			
Left			

Additional Test Results/Comments:_____

Hearing Aid Recommended

Ear	Manufacturer	Model	Style	Technology	Warranty (years)	Loss & Damage (years)	Approx. Invoice Cost (each)
			❑ BTE ❑ ITE	❑ Digital ❑ Programmable ❑ Analog			
			❑ BTE ❑ ITE	❑ Digital ❑ Programmable ❑ Analog			

Provider Name:	Phone Number:	Email Address:
Medicaid Provider Number:		